CARDIOVASCULAR CARE BEST PRACTICES CHECKLIST

June 2017

This checklist is a resource for athletics health care administrators to help member schools establish a cardiac care policy consistent with the Interassociation Consensus Document on Cardiovascular Care of College Student-Athletes.

1. Pre-Participation Evaluation of Student-Athletes

- ☐ The purpose of the evaluation, as stated in the 2014-15 NCAA Sports Medicine Handbook, is explained to the student-athlete.
- ☐ The cardiac evaluation includes, at minimum, a comprehensive personal and family history, and physical examination, such as the American Heart Association 14-point evaluation or the Pre-Participation Physical Evaluation Monograph, Fourth Edition.
- ☐ The pre-participation evaluation either is conducted on campus under the supervision of the institution's director of medical services or is reviewed by a process that is supervised by the institution's director of medical services.

If an electrocardiogram (ECG) is included in addition to history and physical screening, best practices include:

- ☐ Pre-ECG screening planning is performed with a multidisciplinary team.
- ☐ The student-athlete is provided an in-depth explanation for the rationale of ECG screening and the possible risk vs. benefit of adding ECG screening.
- ☐ Modern athlete-specific ECG interpretation standards are used.
- ☐ Skilled cardiology oversight is available.

2. Emergency Action Plan for Cardiac Arrest

A written emergency action plan for treatment of cardiac arrest is in place and has been reviewed and rehearsed among the following key personnel:

- ☐ All primary athletic healthcare providers (athletic trainers and team physicians).
- ☐ Athletics director and director of medical services.
- ☐ All strength and conditioning coaches.

The emergency action plan for cardiac arrest addresses each of the following:

- ☐ All athletic trainers, team physicians and strength and conditioning coaches have received training/certification in CPR and automated external defibrillator (AED) use.
- ☐ A communication system has been established that ensures a rapid and coordinated response to cardiac arrest, both internally and for emergency medical services.
- ☐ AEDs are placed strategically near all high-risk venues, including weight rooms, indoor arenas/courts, practice facilities, stadiums and fields where organized sports take place.
- ☐ Signage is clearly visible and strategically placed to indicate the location of each AED.
- ☐ AEDs are never behind locked doors and are checked (with appropriate sign-off) at least monthly for proper battery charge and functional electrode pads.
- ☐ Emergency medical service entry and exit are pre-determined and secured for all high-volume events.

CONCUSSION SAFETY PROTOCOL CHECKLIST

June 2017

This checklist is a resource for athletics health care administrators to help member schools establish a concussion safety protocol that is compliant with NCAA Concussion Safety Protocol Legislation and consistent with the Interassociation Consensus: Diagnosis and Management of Sport-Related Concussion Best Practices.

1. Preseason Education

Education management plan that specifies:

- ☐ Institution has provided NCAA concussion fact sheets (NCAA will make the material available) or other applicable material annually to the following parties:
  - ☐ Student-athletes.
  - ☐ Coaches.
  - ☐ Team physicians.
  - ☐ Athletic trainers.
  - ☐ Directors of athletics.
  - ☐ Each party provides a signed acknowledgement of having read and understood the concussion material.

2. Pre-participation Assessment

Pre-participation management plan that specifies:

- ☐ Documentation that each varsity student-athlete has received at least one pre-participation baseline concussion assessment that addresses:
  - ☐ Brain injury and concussion history.
  - ☐ Symptom evaluation.
  - ☐ Cognitive assessment.
  - ☐ Balance evaluation.
  - ☐ Team physician determines pre-participation clearance and/or the need for additional consultation or testing.*

** Consider a new baseline concussion assessment six months or beyond for any varsity student-athlete with a documented concussion, especially those with complicated or multiple concussion history.*

3. Recognition and Diagnosis of Concussion

Recognition and diagnosis of concussion management plan that specifies:

- ☐ Medical personnel with training in the diagnosis, treatment and initial management of acute concussion must be "present" at all NCAA varsity competitions in the following contact/collision sports: basketball; equestrian; field hockey; football; ice hockey; lacrosse; pole vault; rugby; skiing; soccer; wrestling. To be present means to be on site at the campus or arena of the competition. Medical personnel may be from either team, or may be independently contracted for the event.
- ☐ Medical personnel with training in the diagnosis, treatment and initial management of acute concussion must be "available" at all NCAA varsity practices in the following contact/collision sports: basketball; equestrian; field hockey; football; ice hockey; lacrosse; pole vault; rugby; skiing; soccer; wrestling. To be available means that, at a minimum, medical personnel can be contacted at any time during the practice via telephone, messaging, email, beeper or other immediate communication means. Further, the case can be discussed through such communication, and immediate arrangements can be made for the athlete to be evaluated.
- ☐ Any student-athlete with signs/symptoms/behaviors consistent with concussion:
  - ☐ Must be removed from practice or competition.
  - ☐ Must be evaluated by an athletic trainer or team physician with concussion experience.
  - ☐ Must be removed from practice/play for that calendar day if concussion is confirmed.

Initial suspected concussion evaluation management plan that specifies:

- ☐ Symptom assessment.
- ☐ Physical and neurological exam.
- ☐ Cognitive assessment.
- ☐ Balance exam.
- ☐ Clinical assessment for cervical spine trauma, skull fracture and intracranial bleed.

4. Post-Concussion Management

Post-concussion management plan that specifies:

- ☐ Emergency action plan, including transportation for further medical care, for any of the following:
  - ☐ Glasgow Coma Scale < 13
  - ☐ Prolonged loss of consciousness.
  - ☐ Focal neurological deficit suggesting intracranial trauma.
  - ☐ Repetitive emesis.
  - ☐ Persistently diminished/worsening mental status or other neurological signs/symptoms.
  - ☐ Spine injury.
  - ☐ Mechanism for serial evaluation and monitoring after injury.
  - ☐ Documentation of oral and/or written care to both student-athlete and another responsible adult.*
    **May be parent or roommate.*

- ☐ Evaluation by a physician for student-athlete with prolonged recovery in order to consider additional diagnosis* and best management options.

**Additional diagnoses include, but are not limited to:*

- ☐ Post-concussion syndrome.
- ☐ Sleep dysfunction.
- ☐ Migraine or other headache disorders.
- ☐ Mood disorders such as anxiety and depression.
- ☐ Ocular or vestibular dysfunction.

5. Return to Play

Return to play management plan that specifies:

- ☐ Final determination of return-to-play is from the team physician or medically qualified physician designee.
- ☐ Each student-athlete with a concussion must undergo a supervised stepwise progression management plan by a health care provider with expertise in concussion that specifies:
- ☐ Student-athlete has limited physical and cognitive activity until he/she has returned to baseline, then progresses with each step below without worsening or new symptoms:
  - ☐ Light aerobic exercise without resistance training.
  - ☐ Sport-specific exercise and activity without head impact.
  - ☐ Non-contact practice with progressive resistance training.
  - ☐ Unrestricted training.
  - ☐ Return to competition.

6. Return to Learn

Return to learn management plan that specifies:

- ☐ Identification of a point person within the athletics department who will navigate return-to-learn with the student-athlete.
- ☐ Identification of a multidisciplinary team* that will navigate more complex cases of prolonged return-to-learn:
  *Multidisciplinary team may include, but not be limited to:
  - ☐ Team physician.
  - ☐ Athletic trainer.
  - ☐ Psychologist/counselor.
  - ☐ Neuropsychologist consultant.
  - ☐ Faculty athletics representative.
  - ☐ Academic counselor.
  - ☐ Course instructor(s).
  - ☐ College administrators.
  - ☐ Office of disability services representatives.
  - ☐ Coaches.

- ☐ Compliance with ADAAA.
- ☐ No classroom activity on same day as the concussion
- ☐ Individualized initial plan that includes:
  - ☐ Remaining at home/dorm if the student-athlete cannot tolerate light cognitive activity.
  - ☐ Gradual return to classroom/studying as tolerated.

- ☐ Re-evaluation by the team physician if concussion symptoms worsen with academic challenges.

- ☐ Modification of schedule/academic accommodations for up to two weeks, as indicated, with help from the identified point person.
- ☐ Re-evaluation by the team physician and members of the multidisciplinary team, as appropriate, for a student-athlete with symptoms lasting longer than two weeks.
- ☐ Engaging campus resources for cases that cannot be managed through schedule modification/academic accommodations.
    - ☐ Such campus resources must be consistent with ADAAA, and include at least one of the following:
        - ☐ Learning specialists.
        - ☐ Office of disability services.
        - ☐ ADAAA office.

7. Reducing Exposure to Head Trauma:

- ☐ Reducing head trauma exposure management plan.*

**While the committee acknowledges that 'reducing' may be difficult to quantify, it is important to emphasize ways to minimize head trauma exposure. Examples of minimizing head trauma exposure include, but are not limited to:*

- ☐ Adherence to Interassociation Consensus: Year-Round Football Practice Contact Recommendations.
- ☐ Adherence to Interassociation Consensus: Independent Medical Care for College Student-Athletes Best Practices.
- ☐ Reducing gratuitous contact during practice.
- ☐ Taking a 'safety-first' approach to sport.
- ☐ Taking the head out of contact.
- ☐ Coaching and student-athlete education regarding safe play and proper technique.

8. Administrative*

- ☐ Institutional plan submitted to the Concussion Safety Protocol Committee via Program Hub by May 1.
- ☐ Written certificate of compliance signed by the athletics health care administrator that accompanies the submitted plan.

**The administrative checklist items apply only to Division I schools with autonomy and Division I schools that are opting-in to Concussion Protocol Legislation.*

YEAR-ROUND FOOTBALL PRACTICE CONTACT RECOMMENDATIONS CHECKLIST

June 2017

This checklist is a resource for athletics health care administrators to help member schools establish football practice policies that are consistent with Interassociation Consensus Year-Round Football Practice Contact for College Student-Athletes Recommendations.

1. Preseason practice recommendations

Two-a-day practices are not recommended. A second session of no helmet/pad activity may include walkthroughs or meetings; conditioning in the second session of activity is not allowed. The preseason may be extended by one week in the calendar year to accommodate the lost practice time from elimination of two-a-days, and to help ensure that players obtain the necessary skill set for competitive play.

In any given seven days following the five-day acclimation period:

- ☐ Up to three days of practice can be live contact (tackling or thud).
- ☐ There should be a minimum of three non-contact/minimal contact practices in a given week.
- ☐ A non-contact/minimal contact practice should follow a scrimmage.
- ☐ One day should be no football practice.

2. Inseason practice recommendations

Inseason is defined as the period between six days prior to the first regular-season game and the final regular-season game or conference championship game (for participating institutions).

In any given week:

- ☐ Three days of practice should be non-contact/minimal contact.
- ☐ One day of live contact/tackling should be allowed.
- ☐ One day of live contact/thud should be allowed.

3. Postseason practice recommendations

NCAA Championships (Football Championship Subdivision/Division II/Division III), bowl (Football Bowl Subdivision)

If there is a two-week or less period of time between the final regular-season game or conference championship game (for participating institutions) and the next bowl or postseason game, then inseason practice recommendations should remain in place.

If there is greater than two weeks between the final regular-season game or conference championship game (for participating institutions) and the next bowl or postseason game, then:

Up to three days may be live-contact (two of which should be live contact/thud).

- ☐ There must be three non-contact/minimal contact practices in a given week.
- ☐ The day preceding and following live contact/tackling should be non-contact/minimal contact or no football practice.
- ☐ One day must be no football practice.

4. Spring practice recommendations (Divisions I and II)

Of the 15 allowable sessions that may occur during the spring practice season, eight practices may involve live contact (tackling or thud); three of these live contact practices may include greater than 50 percent live contact (scrimmages). Live contact practices should be limited to two in a given week and should not occur on consecutive days. The day following live scrimmage should be non-contact/minimal contact.

MENTAL HEALTH BEST PRACTICES CHECKLIST

June 2017

This checklist is a resource for athletics health care administrators to help member schools establish mental health policies and practices consistent with the Interassociation Consensus Document: Best Practices for Understanding and Supporting Student-Athlete Mental Wellness.

1. Clinical Licensure of Practitioners Providing Mental Health Care

- ☐ Mental health care of student-athletes should be done in collaboration with the primary athletics health care providers (athletic trainers and team physicians) and the licensed practitioners who are qualified to provide mental health services.
- ☐ Formal mental health evaluation and treatment for student-athletes is provided ONLY by practitioners who are qualified to provide mental health services (clinical or counseling psychologists, psychiatrists, licensed clinical social workers, psychiatric mental health nurses, licensed mental health counselors, board certified primary care physicians with core competencies to treat mental health disorders.)
- ☐ Individuals providing mental health care to student-athletes have autonomous authority, consistent with their professional licensure and professional ethical standards, to make mental health management decisions for student-athletes.
- ☐ Individuals providing mental health care to student-athletes should have cultural competency in treating student-athletes from diverse racial, ethnic, gender identified, and other unique cultural experiences influencing help-seeking.
- ☐ Individuals providing mental health care to student-athletes ideally should have cultural competency in working with collegiate student-athletes, as evidenced by professional training related to athletics, continuing education courses related to athletics or other professional development activities or experiences related to athletics.

2. Procedures for Identification and Referral of Student-Athletes to Qualified Practitioners

Mental Health Emergency Action Management Plan (MHEAMP) that specifies:

- ☐ Situations, symptoms or behaviors that are considered mental health emergencies.
- ☐ Written procedures for management of the following mental health emergencies:
  - ☐ Suicidal and/or homicidal ideation.
  - ☐ Sexual assault.
  - ☐ Highly agitated or threatening behavior, acute psychosis or paranoia.
  - ☐ Acute delirium/confusional state.
  - ☐ Acute intoxication or drug overdose.
- ☐ Situations in which the individual responding to the crisis situation should immediately contact emergency medical services (EMS).
- ☐ Individuals responding to the acute crisis should be familiar with the local municipality protocol for involuntary retention, e.g., if the student-athlete is at risk of self-harm or harm to others.
- ☐ Situations in which the individual responding to the crisis situation should contact a trained on-call counselor.
- ☐ Identifying trained on-call counselors who will be able to provide direct and consultative crisis intervention.
- ☐ The management expectations of each stakeholder within athletics during a crisis situation.
- ☐ Specific steps to be taken after an emergency situation has resolved to support the student-athlete who has experienced the mental health emergency.
- ☐ A procedure for reviewing preventive and emergency procedures after the resolution of the emergency situation.
- ☐ A formal policy for when student-athlete family members will be contacted in the event of a mental health emergency.

Routine mental health referral plan that specifies:

- ☐ Situations, symptoms or behaviors that may indicate a possible nonemergency mental health concern.
- ☐ The licensed mental health professional to whom student-athletes with possible nonemergency mental health concerns should be referred.
- ☐ Who should be responsible for making the referral to a licensed practitioner who is qualified to provide mental health services.

Communication about mental health management plans:

- ☐ MHEAMPs are provided to all stakeholders

within athletics who work with student-athletes, clearly specifying each stakeholder's role in managing a crisis situation.
- ☐ Annual communication is conducted with all stakeholders within athletics who work with student-athletes about the importance of reviewing their role in all emergency action plans – specifically the MHEAMP.
- ☐ All stakeholders within athletics who work with student-athletes are provided with written instructions about the practitioners to whom student-athletes with potential nonemergency mental health concerns should be referred.

3. Pre-Participation Mental Health Screening

- ☐ Screening questionnaire(s) for mental health disorders are considered as part of the pre-participation exam.
- ☐ A procedure is established for when and to whom symptomatic or at-risk student-athletes identified through this screening process will be referred.
- ☐ All decisions related to what approach will be taken to screening (including what screening instrument to consider and what responses or scores on this instrument warrant further follow-up) will be made by the primary athletics health care providers (athletic trainers and team physicians) in collaboration with the licensed practitioners who are qualified to provide mental health services.
- ☐ Examples may include those listed in Appendix F of the Interassociation Mental Health Best Practices.

4. Health-Promoting Environments that Support Mental Well-Being and Resilience

- ☐ The primary athletics health care providers and the licensed practitioners who are qualified to provide mental health services to student-athletes meet on an annual basis and develop strategies for educating student-athletes about institutional procedures for mental health referrals and management.
- ☐ All SAAC representatives and student-athletes receive information on an annual basis about:
  - ☐ Signs and symptoms of mental health disorders and how to obtain mental health guidance from the primary athletics health care providers (athletic trainers and team physicians) and licensed practitioners who are qualified to provide mental health services.
  - ☐ Programming about preventing and responding to sexual assault, interpersonal violence and hazing.
  - ☐ Programming about peer intervention in the event of teammate mental health distress.
- ☐ All coaches and faculty athletics representatives receive information on an annual basis about:
  - ☐ Programming to support appropriate first response to emergency situations.
  - ☐ Signs and symptoms of mental health disorders.
  - ☐ The importance of, and how to, create a positive team culture that promotes personal growth, autonomy and positive relations with others.
  - ☐ Information about sexual assault, interpersonal violence and hazing.
  - ☐ How to encourage and support team members who are facing mental health challenges to seek appropriate management and referrals from the primary athletics health care providers (athletic trainers and team physicians) and licensed practitioners who are qualified to provide mental health services.
  - ☐ The specific referral process that coaches should follow if they are concerned about a student-athlete's mental health.
  - ☐ The importance of understanding and helping to minimize the possible tension that can exist in student-athletes about adverse consequences for seeking mental health care.